SEX AND THE YALE STUDENT

Student Committee on Human Sexuality

introduction

Another book on sex? Hasn't it all been written 10,000 times before? Perhaps - but don't close the pamphlet too hastily. This is a Yale pamphlet, by and for Yale students, and centered on our concerns and our questions about human sexual functioning. Naturally, some of you will know more about sex than others. So some of this book may seem old hat. But we've tried to have it relate to the gamut of sexual experience. It contains the most recent information and list of services available and has been checked for accuracy by our advisors.

The idea for the pamphlet arose out of a non-credit course on human sexuality which was directed by Dr. Philip Sarrel at Yale in the spring of 1970. As the group of students planning and evaluating the course, we felt that at least some of the information on human sexuality should be available to everyone - not just to those people who attended the lectures. Thus, this little book - a synthesis of the major concerns of the course, and written with the student's needs and experience in mind. We, the student writers, have learned a great deal in producing the pamphlet, and we hope it will be both interesting and useful to you.

"We all get by with a little help from our friends..."

The Committee on Human Sexuality

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Cover: Philadelphia Museum of Art

Extra copies of this pamphlet are available to members of the Yale community. For information call 436-3592.

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anatomy and physiology

Genital anatomy, menstrual physiology, as well as sexual response anatomy and physiology have all been the subjects of many students' questions. It has become obvious that no one knows everything and that almost everyone holds at least one rather basic misunderstanding about their sex anatomy and physiology.

Questions asked this year have included: "When actually is it that I can become pregnant?" "Do I have a clitoris?" "I think I've had an orgasm, but can you tell me if I've ever had one?" "I'm not sure, but I think I'm still a virgin. Can you tell me?" "What is a virgin anyway?" "Can you get pregnant if you have intercourse during a period?" "My boyfriend came outside me. Is it possible that I can become pregnant?" "Does it hurt my boyfriend if we pet without having intercourse?"

The questions are many, and few of us have had an education before coming to Yale which taught us the answers. However, we recognize that we cannot fully cover all the issues in the areas of descriptive anatomy and physiology. Our point is simply that no question is too simple and that everyone has several resources available for answering such questions.

The evening elective course in human sexuality directs itself to these subjects. As a result of student suggestions, part of last year's course funds has been used to establish a "sexuality shelf" in each of the residential college libraries. A set of books has been selected and made available on that shelf for the use of all students. Questions about anatomy and physiology are particularly well answered in the following books included in that collection: Brecher and Brecher's An Analysis of Human Sexual Response*; Reuben's Everything You Always Wanted to Know About Sex but were Afraid to Ask; and Guttmacher's Pregnancy and Birth*. The starred (*) books are also part of the reading for the course in human sexuality.

The Sex Counseling Service, discussed more fully in the section on Yale services, has as one of its concerns the answering of questions about sexual anatomy and physiology.

In this booklet, we have included a separate section, "Questions Students Ask". Some anatomy and physiology questions are discussed in that section.

The Sex Counseling Service served several hundred students last year and answered at least that many questions about sexual behavior and attitudes. The following questions are a sampling included here to indicate the kind of questions students ask as well as the kind of responses the Sarrels have given:

Should intercourse be avoided during a menstrual period?

Some cultures believe that a woman is unclean at the time of her period, and therefore those cultures prohibit intercourse at that time. However, there is no data to indicate that intercourse at the time of the period causes infection or any other physical problem except, perhaps, conception. Studies have been done which indicate that a woman's sex response may be cyclical, i.e. that there are times in the month when she is "turned off" and other times when she feels very sexually responsive. Some women are more "turned on" immediately before and/or during the time of their period. However, they or their partners may be inhibited by the "mess". One way of getting around this problem is to use a diaphragm. It is of some value as a contraceptive but is perhaps even more appreciated in this case because it holds back the flow of blood and makes intercourse more aesthetically pleasing.

It should be noted, however, that intercourse during a menstrual period can result in pregnancy. Many people believe that a woman is absolutely "safe" at this time, but that is not so. Let us take, for example, a student who has six to seven day periods and who menstruates every twenty-five days. We know that ovulation occurs about fourteen days before the period (in her case, day 11), and we know that sperm can last as long as six or seven days. If this girl were to have intercourse on the sixth day of her period (5 days before ovulation) and if she did not use a method of birth control, she would risk the possibility of becoming pregnant.

Can a man or woman be hurt during intercourse?

There are many women who fear pain at the time of first intercourse. Nowadays, when most women use tampons or have had petting experience, including manual stimulation of the vagina, prior to intercourse, there is already a dilating of the opening of the vagina. Therefore, although there is some pain at first intercourse, it is not at all the traumatic event that some women imagine it to be. One way to avoid pain at the time of first intercourse is to understand one part of a woman's sexual response cycle: that is, that she reaches a point of physiological response, a "pre-orgasmic point", when the vagina opens spontaneously, thus making it much easier for her to have intercourse. One should also understand that unless there is adequate lubrication of the vagina, usually by the woman's own secretions, it is uncomfortable and sometimes painful to have intercourse.

Perhaps the most common cause for painful intercourse that we have seen this year has been a superficial type of infection in the vagina due to yeast. Several couples have been unable to have intercourse because of the pain. These infections are usually cleared up by a short course of treatment. However, some couples do not turn for help. They assume that their pain is of a psychiatric origin and create a sex response problem for themselves. Couples should be aware of the frequency of this type of infection and turn for gynecological help as soon as any symptoms occur.

Women are often concerned that if they have intercourse and their boyfriend does not have a climax it is harmful to him. There is no indication that non-ejaculatory intercourse hurts the man. Males have a spontaneous physiological response, the wet dream, which relieves any congestion that they may experience. In addition, most males use masturbation as a physiological outlet.

There is also the question of whether certain positions during intercourse can be painful. We know that the uterus is often moved at the time of intercourse, and with particularly deep penetration there may be painful motion. For a particular couple this pain may be

experienced in one coital position rather than in others, so some couples have found that they must adjust to certain positions for comfort.

Does a lot of masturbation make it harder to climax?

Both men and women express concern about the effect of masturbation upon their ability to respond during intercourse. Many men have used masturbation before intercourse as a type of birth control, i.e. they masturbate and then have intercourse believing that the sperm supply is exhausted long enough to enable intercourse without release of additional sperm. Two major problems are encountered: first, the refractory period of the male, i.e a period after ejaculation when the male sexual response system cannot respond because of physiological limitations. The result is non-orgasmic intercourse which, on occasion, becomes upsetting and frustrating to the man as well as his partner. The second problem is that it is a poor method of contraception, for sperm can be released soon after an ejaculate, and the pregnancy rate is high using this method.

In women, there are other issues. Some experts "preach" female masturbation as an important kind of training enabling the woman to become orgasmic and thus better preparing her to respond orgasmically with intercourse. However, others claim that masturbation so conditions the female that it becomes more difficult for her to respond to the vaginal stimulation of intercourse. We find that almost all female students go through a phase of non-orgasmic intercourse regardless of their masturbatory experience. For some this period is short (the first few times), but for most a period of several months of an on-going intimate relationship is needed before coital orgasm occurs. Contrary to some popular ideas, we have seen almost no females who were orgasmic the first time they had intercourse.

Several things about masturbation should be made clear. Fear of being physically hurt by too much masturbation is unrealistic - the body will stop responding at a physiological point before injury can occur. Masturbation is a widely practiced and widely accepted

type of behavior providing an important outlet for sexual tension. Masters and Johnson's studies indicate that the intensity of sexual response can be greater as a result of masturbation than from other kinds of sexual behavior, intercourse included. However, intensity of response should not be confused with the meaning and significance of a sexual experience. It is important to realize that there is a range of feelings and emotions accompanying sex and that these feelings may or may not be related to the intensity of the physiological response.

How do women feel if they "make love" and don't have an orgasm?

Many men have set as a goal of their sex relations making their girlfriend come. For most women this is a kind of superficial goal, and, although there are times when they wish very much to have an orgasm, there are many times, in contrast to the male, when they are perfectly happy and satisfied with sexual relations even though they have not had an orgasm. Although women readily accept this idea, men find it difficult to appreciate this capacity of women to feel fulfilled by non-orgasmic sexual relations.

One of the factors which influence a woman's orgasmic capacity is the phase of her menstrual cycle. Studies indicate that women go through regular phases of being "turned on" and other phases when they are "turned off". Perhaps most important for students who don't use birth control is the finding that one time in the cycle when women are very "turned on" (i.e. become orgasmic more easily) is the time of ovulation.

Another factor influencing female orgasm is the belief that orgasm is necessary for conception to occur. Certainly, orgasm is helpful in the male for conception to occur, although there can be sperm leaking from the penis which will cause conception without a male's orgasm. In the female, orgasm is not necessary for conception. Many women "hold back" because of a fear that if they have an orgasm they'll get pregnant or that if they have an orgasm their boyfriend will not be able to withdraw in time for their "coitus interruptus"

method to work.

In our culture, students as well as others have been somewhat tyrannized about orgasm. There are expectations of having multiple orgasms or fantasying to orgasm or having, as one student put it, "technicolor" orgasms. It is our feeling that concentration on mechanics and performance can spoil an otherwise close and meaningful relationship. There are some women who feel the need for orgasm with every sexual experience. We advise couples to talk openly with each other about their response and its meaning for them and for the relationship.

Does the size of the penis influence sexual satisfaction?

For women it is important to realize that all males at some time or another compare their penis size with other males. This occurs, as you will read in Reuben's book, in almost any place where men are together and undressed - whether it be in the locker room, the swimming pool, etc. Masters has shown that, regardless of the non-erectile size of the penis, at the time of erection most penises are about the same size. Perhaps the more critical factor is the realization that the vagina automatically adjusts itself to the size of the penis at the time of intercourse.

Is promiscuity common on the campus?

There is a kind of promiscuity which occurs at the beginning of the school year when students have the feeling of being freed up from restrictions at home and are at the same time looking for an ongoing relationship on campus. Moving from one relationship to another and experimenting sexually within these relationships might be considered promiscuous. However, although there are some students who can have intercourse with more than one person, perhaps not at the some moment but at the same time, most students feel that it's difficult for them to maintain this kind of relationship for a long period of time.

There are a small number of students who have a compulsion to become involved sexually with many different people. Students who are promiscuous and who find themselves

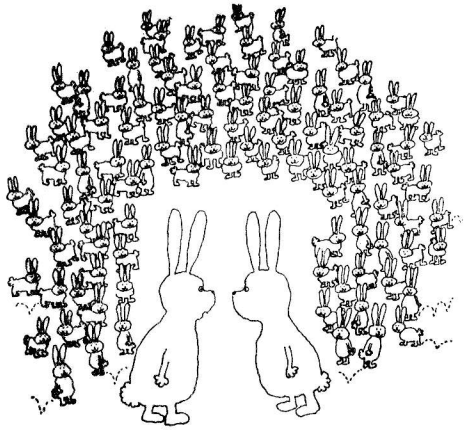
upset by their experiences should come into the Sex Counseling Service or the Mental Hygiene Clinic to talk about it.

Is there something wrong with me because I don't feel ready to have intercourse yet?

Numerous students asked this question last year. Our data indicates that about half of all undergraduates at Yale have not had intercourse. There are many couples who sleep together but who feel that they are not ready to have intercourse until they are ready to make the commitment that birth control implies. Our impression is that most students feel they don't need a marriage license or a ring as a go-ahead for intercourse, but feel rather that intercourse represents something important, something that they want to save for a time when they feel ready for both an emotional as well as a physical sharing.

It is true that there are students who have intercourse simply to get rid of their virginity. For most, this is not a pleasurable or fulfilling experience and seems to us not to be a very good reason for having intercourse. It is important to realize that sexuality is developmental - different people, as influenced by their family, religion, and society, are ready for intercourse at different times in their lives and within different kinds of relationships. We feel that this question is a very appropriate one to present to the Sex Counseling Service.

birth control



"Pill? What Pill?"

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Let's say that you decide to have intercourse - about half of Yale students make such a decision. What should you do next? If you do not wish to become pregnant, you will want to obtain a method of contraception. The best way for you to do this is to make an appointment with the Sex Counseling Service at the Department of University Health. It is really a good idea to come to the counseling service first, before having intercourse. That way you avoid the anxiety of having a possible unwanted pregnancy on your mind. Couples are encouraged to come in together, even if one of the partners does not go to Yale, because birth control usually involves a mutual responsibility. All counseling is done in the strictest of confidence by Dr. and

Mrs. Sarrel. Their purpose is to help you to deal with any personal problems you may have relating to sexual matters. A girl can be examined and can obtain a doctor's prescription for methods of birth control that require one. Dr. and Mrs. Sarrel's service is described later on in the section on Yale services. These services at DUH are included in the tuition fee that all students, with a few exceptions, pay.

Students who have gynecological problems (pain, discharge, bleeding, etc.) and those who wish contraceptive services but have no questions to ask are cared for on Tuesdays and Thursdays by another gynecologist from the medical school. To make an appointment, call 436-4730.

An alternative to the services at DUH, but also a good way for you to obtain a method of birth control, is to go to Planned Parenthood at 406 Orange St. near Trumbull St. in New Haven. Clinics are held Monday and Thursday evenings from 6:30 until 9:00, Wednesday afternoon from 1:30 until 4:00, and Friday mornings from 9:30 until 12:00 noon. When you go to the clinic, a volunteer or a nurse will interview you to get a medical history, and the clinic nurse will describe to you all the methods of birth control. Then you can be examined by one of the doctors. All the doctors at Planned Parenthood are licensed in the state of Connecticut and are specialists in obstetrics and gynecology. You will have free choice of the method of birth control that you wish to use, as long as nothing in your medical history rules it out. However, doctors at Planned Parenthood do not have much time to discuss problems. The fees at Planned Parenthood are scaled; they vary according to income and range from $1.00 to $15.00. Students should state that they are students. To see a doctor at the clinic, you must have an appointment. To get one, call 865-4250 or walk over to Planned Parenthood.

INTERCOURSE WITHOUT CONTRACEPTION

Despite the increasing availability of information on contraception and the trend toward wider distribution of contraceptive devices

themselves, the proportion of illegitimate to legitimate births in the state of Connecticut has remained about 1 to 5. Although occasionally contraceptive failure accounts for a problem pregnancy, the overwhelming majority of them can be traced to a single cause: the man and woman involved were simply not employing any means of contraception when they had intercourse. Why did the couple run the serious risk of premarital pregnancy by failing to take precautions?

In a number of cases the answer was not lack of knowledge of contraceptive methods. Several informed and quite sophisticated female students got pregnant at Yale last year - why? A major factor in these pregnancies was that the people involved had not anticipated that they would have intercourse at the particular time they did have it. Almost all the girls became pregnant within the first few times they had ever had intercourse. Caught in an unexpected situation, the couple was not prepared.

A second factor in premarital pregnancies is often the unwillingness of the couple to take seriously the nature and implications of their relationship. They refuse to recognize fully the meaning of their acts and to take responsibility for them; to take rational contraceptive precautions before having intercourse would represent an explicit affirmation of a mutual involvement whose extent one or both of the couple refuses to face. Such a person is really oblivious to the facts of his situation. Thus, in a study by a Boston University student, Marianne Parker, it was reported that 2/3 of those in a sample group of forty-eight pregnant unmarried women had not taken any precautions to prevent pregnancy because "they did not think it would happen to them". For those of you who have seen the movie, we refer to this as the "Good-bye Columbus Syndrome."

Then, there are the cases of those who deliberately and willfully desire intercourse without contraception. For some, it is a test of male virility whether he can get his girlfriend pregnant. Other people coolly maintain that intercourse without contraception is more exciting because it is more dangerous. Or it may be said that the forethought involved in contraception reduces the romance and spontaneity of the relationship. Finally, there are still some for whom pregnancy provides the means for achieving marriage. (One half of all teenage brides are pregnant.)

There are also students whose pregnancy or "contraceptive failure" represents an expression of an unrecognized emotional need. Some need to punish themselves for having premarital intercourse. Others may subconsciously experience pregnancy as a kind of fulfillment, or as an expression of femininity, or as a way of giving meaning to their relationship.

As students recognizing what a wonderful thing it is to have a baby at the right time and place, we also realize the potential tragedy of becoming pregnant here and now. To all those people who do not practice contraception but who do practice coitus, we can only recommend a careful reading of the section later in the booklet on abortion and on the decisions a couple must face with an unwanted pregnancy. Are any of the above rationales worth the pain and trauma of an unwanted pregnancy?

FEMALE CONTRACEPTION

The Pill

The vast majority of female students on our campus who are employing a method of birth control use the pill. For our age group, the pill, when taken under the supervision of a physician, is probably the safest, most effective, and most enjoyable method of birth control available.

Students on the Pill

Unlike most universities, Yale has a health department that will prescribe birth control methods for students. The policy is to individualize each case to be sure that each

student understands the limitations of all methods of birth control and that the student is aware of any problems that might develop. Requests are honored after suitable medical evaluation. Within this context, the vast majority of students on this campus who use a method of birth control have chosen to use the pill. As a result of word of mouth and the information in the sexuality course, a large number of students who had not had intercourse came as couples or individuals for a prescription. Interestingly enough, several students who thought that they were going to have intercourse started on the pill and then changed their minds. When seen at the time of their follow-up visit, they stated that they felt they were not ready for intercourse but were happy to have been able to prevent pregnancy if intercourse had occurred. The effect of the pill on intercourse on this campus has been for most to remove the anxiety associated with less effective methods of birth control. In addition, last year's experience at DUH indicates that the pill did not promote superficial or promiscuous relationships.

How the Pill Works

There are actually two types of pill now commonly used - combination and sequential. Both types contain synthetic hormones that are very much like estrogen and progesterone, the natural hormones produced by a woman's ovaries. Combination pills contain both estrogen and progesterone in the same pill, while sequential pills are estrogen for the first 15 pills and estrogen-progesterone combination for the last 5 pills. Figure 1 lists the different kinds of pills.

ORAL CONTRACEPTIVES IN THE UNITED STATES

Trademark	Manufacturer	Type	Progestogen	Progestogen mg/tab	Estrogen	Estrogen mg/tab	Total Steroids mg/tab
Oracon	Mead Johnson	Seq.	dimethisterone	25.0	ethinyl estradiol	.10	25.10
Ortho-Novum 10 mg.	Ortho	Comb.	norethindrone	10.0	mestranol	.06	10.06
Provest	Upjohn	Comb.	medroxyprogesterone acetate	10.0	ethinyl estradiol	.05	10.05
Enovid 5 mg.	Searle	Comb.	norethynodrel	5.0	mestranol	.075	5.075
Enovid-E	Searle	Comb.	norethynodrel	2.5	mestranol	.10	2.60
Norlestrin 2.5 mg.	Parke-Davis	Comb.	norethindrone acetate	2.5	ethinyl estradiol	.05	2.55
Ortho-Novum 2 mg.	Ortho	Comb.	norethindrone	2.0	mestranol	.10	2.10
Norinyl 2 mg.	Syntex	Comb.	norethindrone	2.0	mestranol	.10	2.10
C-Quens	Eli Lilly	Seq.	chlormadinone acetate	2.0	mestranol	.08	2.08
Norquen	Syntex	Seq.	norethindrone	2.0	mestranol	.08	2.08
Ortho-Novum SQ	Ortho	Seq.	norethindrone	2.0	mestranol	.08	2.08
Ovulen	Searle	Comb.	ethynodiol diacetate	1.0	mestranol	.10	1.10
Ovulen-21	Searle	Comb.	ethynodiol diacetate	1.0	mestranol	.10	1.10
Ovulen-28	Searle	Comb.	ethynodiol diacetate	1.0	mestranol	.10	1.10
Norinyl 1+80	Syntex	Comb.	norethindrone	1.0	mestranol	.08	1.08
Ortho-Novum 1/80□21	Ortho	Comb.	norethindrone	1.0	mestranol	.08	1.08
Noriday	Syntex	Comb.	norethindrone	1.0	mestranol	.05	1.05
Norinyl-1	Syntex	Comb.	norethindrone	1.0	mestranol	.05	1.05
Norlestrin 1 mg.	Parke-Davis	Comb.	norethindrone acetate	1.0	ethinyl estradiol	.05	1.05
Norlestrin 21 1 mg.	Parke-Davis	Comb.	norethindrone acetate	1.0	ethinyl estradiol	.05	1.05
Norlestrin 28 1 mg.	Parke-Davis	Comb.	norethindrone acetate	1.0	ethinyl estradiol	.05	1.05
Norlestrin Fe 1 mg.	Parke-Davis	Comb.	norethindrone acetate	1.0	ethinyl estradiol	.05	1.05
Ortho-Novum 1 mg.	Ortho	Comb.	norethindrone	1.0	mestranol	.05	1.05
OVRAL®	**WYETH**	**COMB.**	**NORGESTREL**	**0.5**	**ETHINYL ESTRADIOL**	**.05**	**.55**

WYETH LABORATORIES PHILADELPHIA, PA. 19101

Figure 1

After ovulation, progesterone normally instructs the pituitary gland to stop secreting the hormones that cause ovulation. If the released egg has become fertilized, progesterone is continually produced and suppresses ovulation throughout pregnancy. Because the pill contains synthetic progesterone, taking it every day makes you "pseudo-pregnant" and thus suppresses ovulation. This is one way in which birth control pills work.

The pill also works in other ways. It causes the mucus around the cervix, or opening to the uterus, to thicken. Thus, the mucus becomes unreceptive to sperm; they cannot penetrate. The pill may also change the lining of the uterus in such a way that a fertilized egg cannot become implanted in the uterus wall and start to grow. In this way, the pill safeguards you in case an egg is somehow produced and succeeds in being fertilized.

There is a bonus involved in taking the pill in addition to its contraceptive effects. The progesterone in the pill prevents the uterine lining from becoming overgrown, and so, a woman taking the pill has a more normal, often lighter menstrual flow. For this reason, the pill is sometimes prescribed to regulate painful menses and to control heavy bleeding.

Taking the Different Kinds of Pills

If you are taking either of the two kinds of pill exactly as prescribed, there is only minimal chance that you will become pregnant. Both kinds of pill are more effective than any other birth control method; but, the combination pill is a little more effective than the sequential pill.

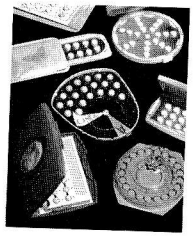


Figure 2

The schedule for taking both kinds of pill is just about the same. They are usually taken for 20 or 21 days each month, starting on the 5th day of the menstrual cycle (the first day of bleeding is "day 1"). Pills are not taken for the last 7 days of the cycle. For more details about exactly when the pills should be taken and which day is counted as "day 1", ask your physician or pharmacist for the booklet that goes along with the brand of pills that has been prescribed for you. Such a booklet can be very helpful.

Menstruation usually starts 3 to 5 days after the last pill was taken. This sort of schedule results in a menstrual flow about every 28 days. But, sometimes menstruation does not occur within 3 to 5 days after the last pill. If this happens to you, don't panic. This is not necessarily an indication of pregnancy, and you should start the next month's pills just as usual. However, if you miss two consecutive periods, you should consult with your physician.

You should also remember to take the pill at about the same time each day. This is important because it keeps a constant hormonal level in your body. Also, it's not as easy for you to forget to take your pill if taking it becomes part of the routine of a certain time of day.

The effectiveness of the pill depends on your taking it exactly as prescribed. If you forget to take a pill, you should take it as soon as you realize your mistake. Then take the next pill at the regular time, even if this means taking two pills in one day. Don't worry- forgetting one pill rarely results in pregnancy. However, if you forget to take the pill for more than one day, you might use another contraceptive method (preferably mechanical) in addition to the pills for that cycle. You should also consult your physician because failing to maintain the series may disrupt your menstrual cycle.

It was thought that the sequential pill more closely resembled a woman's natural hormonal sequence than did the combination pill. The sequential pill was also thought to suppress the pituitary gland to a lesser degree than the combination pill, and, therefore, sequential pills were sometimes prescribed for girls whose pituitaries had not yet developed a regular menstrual cycle. However, recent research has not tended to support these ideas. Combination pills are generally prescribed at Yale because they are more effective and usually contain lower doses of estrogen than do the sequential pills. It is most probably the estrogen in birth control pills which causes the very rare serious complications. (See Figure 1 to identify the low dose estrogen pills).

Minor Side Effects

Because the pill makes you pseudo-pregnant, you may experience minor side effects which are like a small touch of pregnancy. Nausea, similar to morning sickness, is the most frequent symptom. Breast enlargement and a gain or loss of weight are other common side effects. Some women experience irregular bleeding or spotting, increased vaginal discharge, headache, dizziness, or backache. Mental depression during the first cycle on the pill is fairly common. Most women take a while to realize that the pill is the cause of their feelings. Fortunately, this symptom, as well as the others, almost always disappears

by the second or third cycle of use.

In contrast to these unpleasant effects, you may even experience some positive side effects. Many women claim freedom from pain, swelling, and vaginal discharge before periods; regular periods with reduced menstrual bleeding (occurs in most cases); relief from menstrual cramps; increased breast size; and, increased sexual pleasure (often due to freedom from worry over possible pregnancy).

When you stop the pill - Most women who have been on the pill have become accustomed to their periods occurring every 28 days like clockwork. When the pill has been stopped, however, it takes an average of 6 to 8 weeks for the pituitary to resume stimulating the ovary and for a period to begin (just like after a pregnancy). Many students stop the pill during the summer break if they don't realize that their next period is going to be delayed. When it doesn't come, they can be very upset. Therefore, students are usually told about this effect of the pill and are advised not to discontinue it if the interval between stopping and restarting the pill is to be less than two months. Occasionally, a period does not begin within 8 weeks of stopping the pill. If this happens to you, consult a gynecologist so that he can help you to regulate your periods.

Major Complications - Very Rare

These deserve mention here mostly because news reports may have you unnecessarily worried. Major complications are so rare that the pill still remains the most widely prescribed method of birth control.

Thromboembolism: It has been reported that there is a connection between the use of the pill and the increased incidence of thromboembolic, or blood clotting, disease. It is believed that estrogen affects the blood clotting mechanism in susceptible women. Results from three major studies in Great Britain, published in 1967-1969, maintain that the incidence of thromboembolic disease appears to be several times higher among women taking the pill than

among comparable women not on the pill. The excess death rate from thromboembolic diseases attributable to use of the pill was estimated to be 3 deaths per 100,000 users, of which only 1.3 per 100,000 users were aged 20 to 34. Newer studies of pills with lower estrogen doses indicate a lower incidence now estimated to be 1/3 of the above stated statistics.

The symptoms of thromboembolism include sharp leg pain, blurring of vision, sharp chest pain, or shortness of breath. If such symptoms occur, you should be seen by a physician at DUH immediately.

Cancer: The pill has not been shown to cause any form of cancer. In fact, the annual examination that goes along with taking the pill affords the advantage of early diagnosis of cervical cancer. Also, a breast examination is usually included at the time of a contraceptive check-up.

Advantages of the Pill

1. Most effective method of birth control.
2. Safe to use.
3. One of two contraceptives (IUD is the other) whose use is independent of sexual intercourse.
4. Effects are readily reversible.
5. Often eliminates menstrual cramps, lightens menstrual flow, regulates periods.

Disadvantages and Considerations

1. Must be prescribed by a physician. This involves a pelvic examination.
2. Temporary minor side effects in some cases.
3. Extremely rare but serious complications.
4. You cannot start the pill the minute you decide to have intercourse. It must be started on the 5th day of the menstrual cycle, and it is not guaranteed effective until at least after the first week's usage.
5. Not all women can take the pill because it has some non-dangerous metabolic effects that go unnoticed in most women but that

can aggravate existing conditions in some women. Therefore, if you have a history of diabetes, heart disease, liver malfunctions, migraine headaches, high blood pressure, or breast cancer, you should be extra careful and inform your physician of your condition and any changes you notice.

6. Delay in getting your period after you stop using the pill.

I.U.D.

A small group of students had intrauterine devices inserted last year to serve as their method of birth control. Two girls chose the I.U.D. because their parents, frightened by the publicity about oral contraceptives, insisted that they stop the pill and use the next best method available. For another girl the I.U.D. was chosen because she developed leg cramps on the pill, and, although she was reassured that she did not have phlebitis, she felt that she did not want to take any chances. Still another student chose the I.U.D. because she felt that she would never remember to take the pills. Others chose the I.U.D. because, as they put it, they felt they had been on the pill for too long (one girl had been on the pill continuously for nine years). For all, the I.U.D. represented the next best method to the pill, and they all had a particular reason why they did not want to take or could not take the pill.

Half the I.U.D's fell out. Two were removed for cramps. The rest, about a half-dozen, are now being used without problems.

The I.U.D is an ancient method of birth control. In various forms it is described by Hippocrates and also was used by the ancient Persians. In the earlier part of this century, I.U.D.'s were developed in the form of a steel ring in Germany. However, because of the materials used and the conditions under which the I.U.D's were inserted, the problems of infection and hemorrhage limited widespread use. Eventually, the I.U.D. was banned. In recent years, new I.U.D's have been developed. As a result, it is now an available method which is in use

throughout the world and is one approach that students should know about.

I.U.D's are effective; they are safe; and they have been used by students on the campus. Still, it is our feeling that the I.U.D. is not that relevant to the needs of the college student who has never been pregnant. This reluctance to prescribe the I.U.D. for women who have never been pregnant is based upon increased rates of expulsion of the I.U.D., pain, vaginal discharge, and infection in such women. However, for those who may use the I.U.D. in the future, for those never-pregnant women for whom an I.U.D. may be developed in the near future, for those who for some reason cannot use the pill, and for those who want simply to know about all methods of birth control, we include this discussion of the intrauterine device.

Medical Status of the I.U.D.

Over 100 different types of I.U.D.'s have been described and are in current usage. Figure 3 shows those devices which are most commonly in use in this part of the United States. On the campus this year the Lippes Loop was most commonly used, followed by the Dalkon Shield. Other gynecologists in New Haven also use the Saf-T-Coil, the Marguiles coil, the Majzlin spring, and the Birnberg bow.

A combination of steroid chemists, enzyomologists, histologists, physiologists, anatomists (including electronmicroscopists) have all studied the I.U.D. But, at this time there is still no clear understanding of how it works. Theories include:

1) an effect upon the passage time of the egg through the uterus.
2) an altering of the lining of the uterus changing its receptivity to egg implantation.
3) a change in the enzymes present in the lining of the uterus which will allow a fertilized egg to grow within the uterus.
4) hormonal effects upon the menstrual cycle altering the length of time that the corpus luteum is effective.

et al!

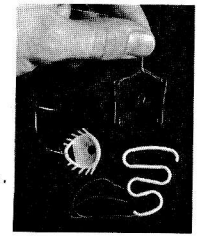


Figure 3

Majzlin spring
Dalkon shield
Lippes loop

It should be stressed at this time that none of these theories has been proved and that about the only thing clearly obvious about the I.U.D. is that it works.

How well do they work? In papers recently delivered (1970) different types of I.U.D.'s have been shown to be close to 98% effective. However, the problem of pregnancy still exists as well as the side effect problems of bleeding, infection and "fall out". When these problems were explained to one student this year who wished to switch from the pill to the I.U.D., none of the side effects made an impression on her except that of pregnancy. When she was told that there was a 2 per cent failure rate, she stated, "Well let's forget about the whole idea of the I.U.D., I'll stay on the pill. I don't want to be even 2 percent pregnant."

Discontinuance rates with the I.U.D. have improved as newer and better devices have been developed. For women who have never been pregnant, however, the discontinuance rate is still over 50 per cent. Unfortunately, in some instances an I.U.D. can fall out without a woman's knowing about it, and this has led to pregnancies here in New Haven.

The I.U.D. is inserted at the time of a period. This time is used because the canal leading to the cavity of the uterus, the cervix, is open while the woman is menstruating, and it is easier to insert an I.U.D. at that time. In this country, the insertion is almost always done by a physician. It is done as an office procedure and does not require anesthesia, although pain similar to a menstrual cramp may be experienced. Within 10 to 15 minutes the cramp usually disappears. In one instance this year, the I.U.D. had to be removed within 15 minutes as the pain persisted. However, that kind of experience is unusual.

After insertion of the I.U.D., the student is asked to check herself to be sure that the I.U.D. has not been expelled into the vagina without her realizing it. She is re-examined after her next period to be sure that the I.U.D. has not been expelled. It is important to continue checking as long as

the I.U.D. is in place, for the I.U.D. can be expelled at almost any time over the years, and a woman would not know about it if she didn't check herself regularly. There is no time limit placed on how long an I.U.D. can remain in the uterus, and some of the original steel rings were in place for over 30 years.

Students are charged $25 for insertion of an I.U.D. The cost range in private offices for insertion of I.U.D's is between $25.00 and $100.00. The fee usually includes the follow-up visit.

Advantages of the I.U.D.

1. Use is independent of sexual intercourse. Once inserted, little thought need be given to it except for occasional checking.
2. After the initial cost of the insertion, there are no additional expenses except for an annual checkup.
3. The method is totally reversible, and fertility is not impaired.
4. The I.U.D. is not felt at the time of intercourse.

Disadvantages and Considerations

1. High expulsion rate in young women.
2. Side effects such as pain or bleeding which may warrant removal.
3. May slip out without one's knowing about it.
4. The possibility of infection.
5. Discharge and odor.
6. Not as effective as the Pill.

Diaphragm and Jelly

Before the advent of the pill, the diaphragm was the method of birth control most recommended by physicians and by clinics. It was used by about one fourth of all U.S. couples employing any form of contraception.

The diaphragm is made of soft rubber and is shaped like a bowl with a spring made of either flexible steel or highly tensile coil at the outer edge. Always used with a spermicidal jelly on its surface, the diaphragm provides a mechanical barrier to sperm swimming toward the cervix. The spermicidal preparation is commonly put within the dome of the cup so that when the diaphragm is inserted into the vagina, it keeps the preparation in contact with the uterine opening. The spermicide kills any sperm that may get past the rim.

To use a diaphragm, a woman puts a small amount of spermicidal jelly or cream into the bowl of the diaphragm and also spreads some evenly on the outside of the bowl. She then compresses the opposite sides of the rim together so that the diaphragm folds in the middle - into a sort of flattened figure eight - and inserts the now flattened shape into the vagina. It is then released in the upper and larger portion of the vagina, fitting securely between the rear wall of the vagina and the upper edge of the pubic bone, where it covers the cervix completely. The flexible rim enables it to resume its original molded shape as soon as the edges are released. (See Figure 4).

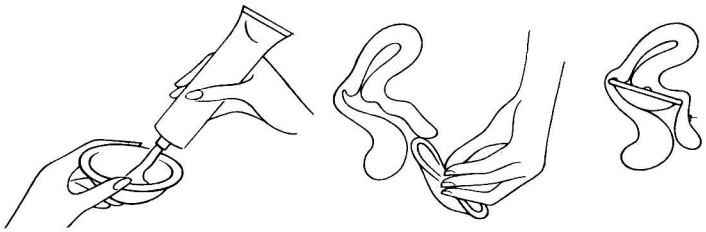


Figure 4

Insertion is usually accomplished manually, but plastic inserters are sometimes useful. The inserter imposes an oval form on the diaphragm which makes passage into the vagina easier. (See Figure 5). The diaphragm is best inserted while standing with one foot on a low stool, sitting on the edge of a chair, or squatting to give high reach up the vaginal passage. It takes practice to learn to insert the diaphragm correctly, and proper insertion is essential.

The diaphragm should not be inserted more than 2 hours before coitus, and must not be removed until 6 hours after the last ejaculation since it takes that long for the spermicide to work. A douche should not be used within this 6 hour period because it dilutes and reduces the effectiveness of the spermicide. The diaphragm may be left in place for as long as 24 hours after which it should be removed and washed with soap and water. One application of spermicidal cream or jelly on the surface of the diaphragm provides protection against only one ejaculate. A syringe-like applicator is used to inject more of the spermicide into the vagina before each additional coitus without removing the diaphragm.

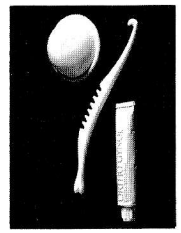


Figure 5

A medical prescription is required by law in order to buy a diaphragm. This should insure that a woman is properly instructed in the use of the diaphragm and that there is no medical danger to her in its usage. In any case, a diaphragm must be fitted by a doctor so that it securely covers the cervix. This is necessary because the dimensions of the vagina from the area behind the cervix to the pubic bone vary, and diaphragms are therefore available in specific sizes. The fitting procedure is painless. When a properly fitted diaphragm is properly inserted, it goes unnoticed by either partner during coitus. Diaphragms should be refitted annually at the time of the annual pelvic examination.

Advantages of the Diaphragm

1. No side effects.
2 Insertion is before intercourse, but need not cause disturbances of foreplay. Need only to use it at time of intercourse.
3. Cost of the diaphragm is only $4.00 to $5.00 and it may last up to two years. Spermicide costs only 10 cents to 15 cents per application.

Disadvantages and Considerations

1. Pregnancy rate of 5 to 12% (depending

upon which study you read).
2. The mess.
3. Hiding the diaphragm and remembering it can become a hassle.

Vaginal Spermicidal Contraceptives

The use of spermicidal preparations themselves, without a diaphragm, has become an accepted method of birth control. Vaginal spermicides are available in different forms: jellies, creams, aerosol foams. (See figure 6). Other less effective ways to introduce spermicidal preparations into the vagina are suppositories and foaming tablets.

Figure 6

Vaginal spermicidal contraceptives work in two ways: the spermicidal chemical inactivates and kills any sperm present; and the non-reactive base, which makes up the bulk of the preparation, serves to block the cervix mechanically, thus preventing the entrance of sperm into the uterus. The chemicals which make up the spermicidal preparation are generally not very potent. Therefore, there are rarely any side effects or reactions to their use, other than infrequent minor allergic irritations. If pregnancy should occur, even though one of the spermicial contraceptives was used, the baby will in no way be affected.

Instructions come with the products, but the method is about the same for all of them. Jellies, creams, and foams come with a syringe-like applicator (see Figures 6 and 7); suppositories and foaming tablets are inserted by hand. All of these products are further distributed by coital movements. You must apply all these preparations within the hour, and sometimes the half hour, immediately preceding coitus. Also, you must insert new applications of the product you are using before each act of intercourse and often after getting up from the bed for any reason. The woman should not douche or take a bath for at least 6 hours after the last ejaculation; it takes that long to insure that all the sperm present have been killed.

There are, however, advantages to the use of spermicides. First, this method may be

combined with others such as a diaphragm or a condom for extra protection. When used with a condom, the combination is over 90 per cent effective. Second, this method only needs to be used when intercourse is to occur, an advantage if intercourse is infrequent. Third, the chemicals do not interfere with sensation during intercourse. And, fourth, no prescription is necessary to buy these products; thus, no pelvic examination is required. The products are available on the counters of most drugstores; and, they are inexpensive - about 10 or 15 cents for each application. Delfen and Emko are reliable product names.

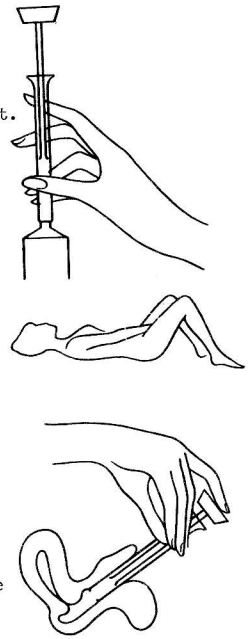


Figure 7

Foams are considered more effective than either creams or jellies. Jellies are not very effective because they sometimes spread out in an uneven way and do not kill some of the sperm. Foaming tablets are more effective than suppositories, but both methods have limitations in that they must be left in the vagina for several minutes before coitus in order that the chemical agent may spread over the cervix. Failure to observe this waiting time is one of the main causes for the lesser effectiveness of this method. The use of non-foaming suppositories for contraception is not advisable because they often do not completely block the entrance to the uterus and they often fail to melt sufficiently.

Most objections to this form of contraception, other than its lesser effectiveness, are aesthetic ones. Use of a vaginal contraceptive must be anticipated and prepared for, or the couple must interrupt sexual foreplay in order to apply it. A second disadvantage is that of "messiness" or vaginal leakage. This complaint is often related to the type of product; choice of product should depend on the individual needs of the couple, most particularly the amount of natural lubrication produced by the woman's vaginal tract during intercourse. All of the products provide some lubrication (sometimes an advantage), but excessive lubrication can be a disadvantage. Jellies are more lubricating than creams; foams are only moderately lubricating.

We view this method as an interim measure either until more effective approaches are obtained or until its use is no longer

indicated. It should not be used as an ongoing method of birth control.

Rhythm

Practicing temporary abstinence from sexual intercourse during a woman's fertile period is called the rhythm method of contraception. No artificial product is employed in this method. When rhythm is used, sexual intercourse is avoided on the days between one menstruation and the next when an egg is, or is soon to be, in the Fallopian tubes - in other words, on the days shortly before, during, and shortly after ovulation. Abstinence for a while before ovulation is necessary because the sperm from the last intercourse remain alive in the uterus and Fallopian tubes for several days; and, abstinence for a while after ovulation is necessary because an egg can be fertilized for some time after ovulation. Rhythm attempts to avoid conception by permitting sperm to be present in the woman only when the ripened egg is thought to be absent.

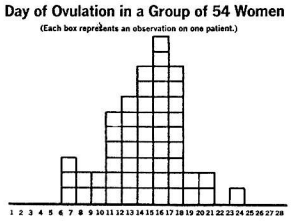
The rhythm method is based on the principle that the likeliest time of ovulation can be predicted by careful observation of successive menstrual cycles. Before using the rhythm method, a woman keeps careful record of her menstrual cycles for at least 8 months, and preferably for one year. A doctor's supervision is absolutely necessary. You should not attempt the rhythm method without guidance.

At the present time two varieties of the rhythm method are practiced; calendar rhythm and temperature rhythm. According to the calendar technique, your day of ovulation can be estimated by means of a formula based on your individual menstrual history recorded over a number of months. The temperature technique of estimating time of ovulation involves determination of your body temperature when you are at rest; this is called your basal body temperature. A drop in basal body temperature with a duration of about 24 hours occurs before ovulation. An elevation in basal temperature for the remainder of the ovulatory cycle occurs after ovulation; this is probably due to the progesterone secreted

after ovulation. (Progesterone is thermogenic). Unfortunately the temperature method is more valuable in planning a pregnancy than in avoiding one, and studies of women using temperature as a guide have established pregnancy rates between 6% and 24%.

Most authorities caution against the rhythm method as unreliable for the great majority of women. There are inherent limitations in both forms of rhythm. Menstrual cycles are subject to frequent variation, sometimes caused by psychological changes in the woman's environment. Illness, shock, or other physical or emotional changes can disturb your menstrual cycle and upset the calculations of the time of ovulation. Thus, ovulation could occur during a time which you had calculated to be "safe". If your menstrual periods are irregular, your safe and unsafe days will be irregular and independent of any calculation.

The very high incidence of cycle irregularity in women 13 to 22 years old makes the rhythm method an especially unfavorable and unadvisable one for younger individuals. (See Figure 8 for illustration of variety of days of ovulation in different women).


Day of Ovulation in a Group of 54 Women
(Each box represents an observation on one patient.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
Figure 8

Even when calculating time of ovulation by using basal body temperature, there is no assurance of accuracy. Attempts to determine the exact time relationship between ovulation and basal temperature have indicated that the rise in temperature may occur from one to three days after ovulation. Therefore, even basal body temperature is only an approximate indicator of ovulation time. In addition, basal temperature may become elevated as a result of causes other than ovulation, such as illness or infection. Thus, even a more accurate, combined calendar-temperature method of rhythm would involve the limitations inherent in each individual technique.

Lastly, further variables limiting the effectiveness of rhythm are introduced by survival periods of sperm and ova. The theoretical period of sperm survival after release is 48 hours, of ovum survival, 24 hours. However, both can live longer; sperm have been known to live for as long as a week and remain viable in the Fallopian tubes. Most

eggs are fertilized when sperm are already waiting in the Fallopian tubes at the time of ovulation. If ovulation occurs somewhat earlier than calculated, and if sperm from the last intercourse are still alive, rhythm as a method of contraception may well fail. On the other hand, if ovulation should take place a few days later than expected, the egg, if it survived for about two days, might still be present in the oviduct at the time of first intercourse in the calculated "safe" period. Finally, there are indications that some women may ovulate in response to coitus as do other mamals.

In conclusion, rhythm is rated only moderately effective as a means of contraception. It is not a method to be depended upon if it is essential to avoid pregnancy. Even the most accurate form may easily fail.

MALE CONTRACEPTION

The two forms of contraception in the male that are used with significant regularity are the condom and coitus interruptus. In addition, some males falsely believe that masturbation can deplete sperm and effect contraception. There is no evidence that this method works at all, and there is lots of evidence that it does not work. Pills for males are being investigated, but no satisfactory agents are yet available to the public.

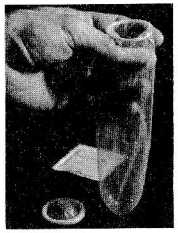


Figure 9

A condom, also known as a "rubber" or "prophylactic", functions by preventing the sperm from entering the vagina and thus from moving through the womb and Fallopian tubes to fertilize the egg. The condom is made of thin rubber or animal gut and is shaped like the finger of a glove. (See Figure 9). It functions not only to help prevent fertilization but also to offer some protection to both partners from contracting venereal disease.

Condoms are effective about 80 per cent of the time, failing when the device ruptures, when semen is spilled, or when the condom used is defective. About one out of every 350 condoms sold is defective, despite the

fact that the devices are spot-checked after production by the Food and Drug Administration. Bursting of the condom can often be prevented by leaving a half inch of space at the end to accommodate ejaculation. Tearing of the condom can also occur during intercourse but normally only when the woman's natural genital secretion is scant. The tearing can thus be prevented by lubrication of the condom with a contraceptive jelly or cream. Spilling of semen may occur when the erection of the penis subsides and the penis is still in the vagina, or when the condom slips off upon withdrawal of the penis from the vagina. The spilling can be prevented by the man's securely holding onto the ring at the top of the condom as he withdraws, and withdrawing directly after orgasm.

Condoms should be bought in drugstores, where they can be purchased without a prescription, and not from the vending machines where they are sometimes sold. Some brand names of reliable condoms are Trojan, Sheik, and Ramses. They can be purchased at approximately $1.80 a dozen or $2.25 a dozen in pre-lubricated form. Thinner condoms, which are not more effective but do convey more sensation, cost up to $7.00 a dozen. There are no varying sizes for condoms, since they conform to any erect penis. Condoms can be kept for more then six months without loss of effectiveness but should not be kept in a wallet, where they can be pierced by sharp objects or become porous due to body heat.

Coitus interruptus is the withdrawal of the penis from the vagina just prior to ejaculation so that semen is deposited outside the woman's genital tract. Medical authorities generally regard coitus interruptus as less preferable than other forms of contraception such as prescribed pills, diaphragms, intrauterine devices and condoms. Coitus interruptus demands a great deal of precision and self-control on the part of the male, especially since the first drops of semen contain the highest concentration of sperm and the release of these drops may not be felt by the male. Splashing of the semen onto the woman's genitals can also occur, and on rare occasion this has resulted in fertilization. Besides being unreliable in preventing conception,

withdrawal often limits sexual satisfaction, especially for the woman who may be slow in coming to orgasm.

Representative Failure Rates for Different Methods of Preventing Pregnancy

Method	Constant Use (per 100 woman years)	Total Use (per 100 woman years)
coitus interruptus	about 15	about 30
condom method	about 5	about 15
diaphragm method	about 3	about 15
intrauterine devices	about 1	about 3
oral contraceptives (The combination method is slightly more effective than the sequential method.)	approximating 0	about 5 (1-5 pills missed per month)
spermicidal preparations	about 4	about 10

Figure 10

METHODS THAT ARE NOT USEFUL

There are a number of other methods of contraception which are used by some couples, but which we do not recommend because of their ineffectiveness or because of the difficulties involved in using them.

The Cervical Cap is a plastic or rubber cup very like the diaphragm, but is much more difficult to use and thus less acceptable. A small cap is placed over the cervix to keep sperm from entering the uterus. Its advantage is that you can leave it in place up to a month at a time. As with the diaphragm, you must go to a physician to get a cervical cap.

Douching is not an effective means of contraception. If it were to be of any help as a contraceptive, the douche would have to be used immediately after intercourse - an unpleasant interruption for the couple. In any case, it is generally a mistake to douche after intercourse in the hope of washing out sperm that have already been deposited. At ejaculation, the sperm are deposited near the cervix, the entrance to the uterus which is about an inch away. An average sperm travels an inch in eight minutes. Thus, by the time douching occurs, some sperm have already made their way into the uterus; others may have just penetrated beyond the reach of

the douching fluid.

No chemical product should be used as a contraceptive unless it states clearly and explicitly that it is so designed. The advertising about many "feminine hygiene" products may imply a possible contraceptive effect, but the products are useless in that capacity (e.g. Norforms). Many of these chemicals are strong coal tar disinfectants which, if not mixed properly, will burn the tissues. They should never be used. It should also be noted that too frequent douching is harmful since it destroys protective bacteria in the vagina and leads to infection by other organisms.

An antiquated sponge method also exists in which a liquid or powder spermicide is put on a small piece of sponge and worked into a foamy consistency. The sponge is then inserted high into the vagina near the cervix. In additon to being of little effectiveness, the sponge, although small, may interfere with intercourse and thus cause you discomfort.

FUTURE METHODS

In additon to the improvement of already existing methods such as the pill and the I.U.D., we can expect in the near future the development of new means of contraception. New methods are already being planned and tested. (1) The Minipill, which is made of a progesterone-like substance and which is to be taken every day, is effective as a contraceptive because it makes the cervical mucus become thicker and the uterine lining become unreceptive to a fertilized egg. It has little effect on the ovaries and ovulation, however, and it fails to regulate periods or prevent menstrual cramps. The minipill failure rate is no better and may be worse than mechanical methods (e.g. diaphragm). (2) The planned Day-after Pill, when taken for a number of days after intercourse, will prevent any fertilized egg from implanting in the uterus, thus preventing pregnancy. (3) A drug is being tested whose effect is to induce menstruation whether or not the woman has been

fertilized during the prior period of fertility. There could be two ways of using such a drug for birth control purposes: it could be used to produce a period at a regular and predictable time in each month; or, it could be used only in those months when the woman thought she was missing a period. The drug would halt development of an embryo at a very early stage. (4) Another method is the once-a-month shot, similar in effect to the pill; it would inhibit monthly ovulation. In some studies a 6-month shot was found to be more effective. Some of the medications for the injections lack estrogen and thus do not have the deleterious side effects associated with it. But menstrual periods become irregular and fertility may be affected for a time after the 6-month shot has worn off. (5) It is also possible that vaccinations can be developed which would produce antibodies in either men or women which would destroy the sperm's ability to fertilize an egg. (6) Some success has been found with the method of implanting small capsules containing a contraceptive drug under the skin so that small amounts diffuse gradually into the circulation. The drug could continue to prevent ovulation for years as it continued to diffuse.

sterilization

Sterilization warrants mention apart from birth control because it is a very controversial subject in its own right. And, for our age group, its use as a contraceptive method is not widespread, a fact which we feel is clearly justifiable.

Sterilization is a surgical way to permanently prevent conception. After thorough discussion, a physician may advise sterilization. For example: when one of the reproductive organs is diseased; when the parents have already produced a child with an inherited nervous or physical disease such as hemophilia; where physical, mental, or emotional factors prevent a couple from caring properly for their child; or when a couple considers their family complete and wishes absolute protection from further pregnancy. Hospital policy varies on this question, the age of

the person involved most often being the decisive factor. The Association of Voluntary Sterilization, Inc. estimates that over 2 million living Americans have been sterilized and that 100,000 are added each year.

FEMALE STERILIZATION

There are four possible surgical methods by which a woman can be sterilized. An oophorectomy, the removal of the ovaries, is not usually done because of the importance of the hormones that the ovaries produce. Hysterectomy, or removal of the uterus, is a complete barrier to pregnancy, but it is not advised unless the uterus itself is diseased. However, if a hysterectomy is done, the ovaries are generally left in place in a younger woman. Many doctors disapprove of hysterectomy as a sterilizing procedure for two reasons: it involves major abdominal surgery with all of its inherent implications; and, the loss of the uterus on occasion has bad psychological effects.

The other two methods of female sterilization involve the Fallopian tubes. Unless they are diseased, the complete removal of the Fallopian tubes, called a salpingectomy, has been given up in favor of a simpler technique known as tubal ligation. This technique is the most commonly used method of female sterilization today. The process involves tying off the Fallopian tubes, effectively preventing the egg from reaching the uterus, and the sperm from travelling to the egg. The unfertilized egg is reabsorbed harmlessly into the woman's body. The woman's monthly periods and subsequent menopause later in life proceed as usual.

Tubal ligation involves a small operation: through a small incision in the abdominal wall or through the vagina, each tube in turn is brought into view and a loop of it is tied off and removed. This operation may be performed after a normal delivery. At that time the uterus is enlarged, making the tubes easily accessible. Tubal ligation may also be done at the time of a Cesarean section. In both cases, the ster-

ilization procedure hardly lengthens the hospital stay. Tubal ligation can also be done when a woman has not been pregnant for some time. In some places, this is done without requiring hospitalization except for the time actually involved in doing the procedure. Recently described techniques of tubal closure include the use of chemicals and of heat. Simpler than currently used operative procedures, these methods may become more widely utilized in the future.

Tubal ligation is a highly successful operation with a failure rate in some reported series as low as one in 1000 (somewhat higher when done after a Cesarean section). Less than 50 percent of the attempts at reversibility have been successful. However, progress is now being made in developing techniques of reversible sterilization. But until improved methods allow for easier reversibility, the operation must be considered permanent.

MALE STERILIZATION

Male sterilization, accomplished surgically by tying the vas deferens, a small duct which carries sperm from the testes to the penis, is usually irreversible. Research is being conducted, however, in developing temporary sterilization by placing surgical thread in the man's genital tract.

Male sterilization and often female sterilization simply involve erecting a detour so that sperm and egg cannot get to each other. The detour usually consists of a roadblock in the form of a surgical knot. Neither method involves hormones, and the sexual response of the individual is not affected, except perhaps by removing the anxiety that pregnancy will occur. It is most important to understand, however, that sterilization should not be requested unless an individual or a couple views the procedure as irreversible.

The major contrast, today, between male and female sterilization is that the male procedure can be done in a doctor's office in about 20

minutes, while the female procedure must be done in a hospital. For the male, sterilization costs about $75.00, including the procedure and the follow-up examination. However, when the hospital bed, operating room, and anesthesia charges are added to the doctor's fee, the cost for a woman is about six times the cost for a man. But, fortunately, many of these expenses can be covered by health insurance.

the morning after pill

If something goes wrong in your contraceptive program (assuming you have some contraceptive program!) - perhaps you forgot to take your pill or maybe your condom burst or came off (almost 50 cases of condom failure were treated last year) - or if you have had unprotected intercourse, there is something you can do to avoid a possible pregnancy!

There is now a pill that can be taken within 3 to 5 days after intercourse to bring on the menstrual period. Dr. John Morris, Professor of Gynecology at Yale, first described the use of estrogen after intercourse to prevent pregnancy. And, that is exactly what the morning after pill is - estrogen. Although most doctors are not familiar with this method, the staff at DUH has had extensive experience with it and feel that it is an appropriate back-up method for students who believe they might have had unprotected intercourse at a time when they could have become pregnant.

If you believe there is a possibility of your having become pregnant on a specific day, and if you want the morning after pill, the first thing you should do is call 436-3592 for an appointment at DUH. Students who have had intercourse on Thursday, Friday, Saturday, or Sunday should call for a Monday morning appointment. Those who have had intercourse on Monday, Tuesday, or Wednesday should call in order to be seen on Thursday mornings. Special appointment times have been set aside so that students requesting post-intercourse contraception can be seen at those times.

After you have made an appointment, buy yourself an oral thermometer. Then, for the next two mornings take your resting temperature. (Your resting temperature is taken first thing when you wake up, before you have gotten out of bed, so make sure you leave the thermometer in easy reach). It is best if you come to your appointment at DUH knowing your resting temperature as the information will be of help to the physician in deciding when you should take the morning after pill. It will also be necessary for you to have an examination so that a doctor can check the cervix for sperm and can also examine the cervical mucus to see whether you are pre- or post-ovualtion. The doctor can then decide if there is any likelihood that you need the morning after pill. Although the morning after pill has proved almost 100% effective, it cannot be used by everyone every time they have intercourse because of its high estrogen content. In addition, as mentioned above, this pill must be taken within 3 to 5 days after the time of contraceptive failure or unprotected intercourse.

The morning after pill has side effects that can be treated - nausea and, occasionally, vomiting. But most people feel that this is a small price to pay for the reduction of anxiety or the prevention of a pregnancy. Still, because of the high estrogen content, the morning after pill should be used only as a back-up method and not as a method of contraception.

FINDING OUT IF YOU'RE PREGNANT

So your period is late...

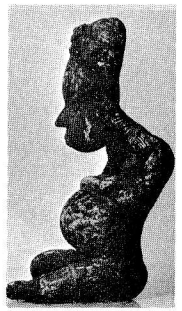
Maybe it is only mid-terms or tear gas or dieting or even recent travel, for any of these can postpone ovulation and consequently your period. Or maybe it's just nerves or stress in adjusting to a new environment.

Or maybe just you are pregnant. Don't panic at the thought. Just take it easy. Don't wait around to get your next period if you are more than a couple of weeks late. While it can be just a case of nerves - why torture yourself? If it isn't just a case of nerves, you will want to know exactly what the problem is - other things, including being pregnant, can stop your period or make it irregualr.

The first thing you should do if you have not had a period for more than 40 days, is make an appointment at DUH to be seen by a gynecologist. Call 436-3736 for an appointment. Any student who feels she is pregnant should not accept routine appointment time; she should say there is an emergency and an immediate appointment will be made. If there is any delay, call 436-3592.

After determining that you are really late, a pregnancy test can be arranged. It must be 42 days from your last period or about 28 days from conception before pregnancy tests will reliably turn positive. (There are new tests which are not routinely done which can discover pregnancy before the first missed period, but under usual circumstances you must wait the specified length of time).

Although being late for your period is the most obvious sign that you are pregnant, you may have already been alerted by several other indications of pregnancy. Some girls feel nauseated - often in the morning. Their breasts feel larger and more tender and the nipples may be especially sensitive. At several months, there may be increased need to urinate - and, of course, with passing time,



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there is weight gain.

An individual may have one of these symptoms or all of them - or some of her very own. (For example, a girl could lose weight if she were sick to her stomach all the time). Whatever it is

GO TO DUH

The pregnancy test is done in strict confidence. If a urine specimen is submitted before 8:30 A.M., you will have the results by the same afternoon. The urine pregnancy test checks to see if the urine contains a hormone called chorionic gonadotropin. If this hormone is present, the laboratory will say the test is positive. If your test turns out positive, you are pregnant. Naturally you will be upset. Just take a deep breath and try to relax. Those students who are pregnant will be counselled at DUH by Dr. and Mrs. Sarrel (in strictest confidence, rest assured).

What if the test is negative? This does not entitle you to jump for joy - yet. While a positive reading is nearly always correct, a negative one can be a false friend. (There are 5% false negative readings). If menstrual bleeding does not begin, re-consult the Sex Counselling Service at DUH.

MAKING A DECISION

If indeed you are pregnant, you must make two major decisions. First you must decide whether or not to have the child. If you decide to have the child, then you must decide whether or not to keep it. Other decisions which you will have to make include whether or not to involve your boy friend, your family and others. Perhaps, most important is the issue of understanding why you became pregnant.

If you decide not to have the child, your alternative is abortion. The change in social climate and in medical practice in recent years has made legal and safe abortion readily available. Yale students will find detailed information on this subject in the section of this pamphlet on abortion and in the

section on Yale services.

If you decide to carry through your pregnancy, you may avoid many of the doubts that often accompany getting an abortion. But, having the child may still involve different problems of its own. You may wish to get married and keep the baby. However, this is not always possible or desirable. Still, one parent alone may want to keep the baby and may be willing to cope with the difficulties. But, if you don't want an abortion and if you don't feel that either of you can keep your child, you might decide to have the child adopted. In any of these cases it should be noted that school policy at Yale allows you to stay in school while you are pregnant. Repeat. No girl will be asked to leave school because she is pregnant. On the other hand, if you wish to leave school because of pregnancy, the Sex Counseling Service will be glad to tell you about living-in resources here and in other communities which students have used in the past.

If you are thinking about having your child adopted, the first thing you should do is to get in touch with one of the licensed child placing agencies in Connecticut. The Counseling Service will be able to advise you, as there are several agencies in New Haven.

State Welfare Department: Bureau of Program Operations
194 Bassett St.
New Haven, Conn. 06500
phone: 562-0861

Children's Center
1400 Whitney Avenue
Hamden, Connecticut 06517
phone: 248-2116

Jewish Family Service of New Haven
152 Temple St.
New Haven, Conn. 06510
phone: 624-1156

Catholic Family Services, Inc. (Diocesan Bureau of Social Service - Archdiocese of Hartford) New Haven, Conn.
478 Orange St. phone: 1-522-8241

These agencies will attempt to find a permanent home for your child. Agencies have long waiting lists of well qualified parents so your child will almost surely be placed. Although some states have strict laws regarding placement by religion, that is not the case in Connecticut, and a child of any religion can be placed through any agency. In recent years, legal adoption of interracial babies has also become a reality.

Adoption, being a legal process, will eventually involve the probate court which has jurisdiction over the adoption process. The court must meet with the child placing agency and the future parents in order to approve, finalize and legalize the adoption. This process safeguards the parties involved.

Again, if you have any doubts about adoption, keeping your child, or carrying through your pregnancy once you are sure that you are pregnant, go to the Sex Counseling Service. Don't panic; you have several alternatives and the Counseling Service can help you make a rational decision that is right for you.

abortion

What happens when birth control is no longer the main concern? What happens when you find yourself the potential mother or father of an unwanted child?

At this point it is no use to castigate yourself or doubt your morality. Once you have determined that you are definitely pregnant, you may decide that you want an abortion.

YOU DO NOT HAVE TO HAVE AN ILLEGAL ABORTION. Repeat. YOU DO NOT HAVE TO LOOK FOR A CRIMINAL ABORTIONIST. Excellent services are available for women who need them. Connecticut statute says an abortion may be legally performed to "save the life of the mother or the fetus." While this does seem a bit cryptic, it does allow physicians to save your life by preventing you from taking matters into your own hands and seeking assistance - and perhaps, death, from a criminal abortionist.

In the chapter on Yale Services, the necessary steps are outlined. It is a simple, private, and safe way to terminate a pregnancy. No one is humiliated or lectured. In fact, by all accounts, Yale and its excellent personnel not only help to reduce personal trauma, but also, oddly enough, have seen the whole experience evolve into a positive one..... Hard to believe - but true.

This section will attempt to explain what the abortion itself is all about, what the methods are, and which are applicable at what times. In all instances, the working definition for abortion is termination of a pregnancy before a fetus can survive.

METHODS OF TERMINATING A PREGNANCY WITHIN THREE MONTHS

There are different methods used for pregnancies of different maturity. Abortions are now being performed in N.Y. and elsewhere up to 26 weeks gestation. However, different techniques must be used depending on the length of the pregnancy. Of the two techniques which are safe and used before 3 months, a "D&C" or Dilatation and Curettage is the most common.

Dilatation and Curettage

At the hospital the D&C is performed using anesthesia. It is painless and quick - usually less than 20 minutes. In the operating room, after the patient is asleep, the doctor causes the cervix (the opening of the uterus) to widen by inserting a graduated set of metal dilators. The first dilator is very small. It is gently inserted and gradually replaced with a slightly larger one. The largest dilator allows the muscular opening to the uterus to stretch about an inch wide, just enough to allow the insertion of a surgical instrument called a curette. The curette is then used inside the uterus to scrape the embryo and placenta off the uterine walls. The only physical after effect may be slight bleeding for a few days

after the operation. You can resume regular activities within a day or two, except that your doctor will restrict intercourse for a short while - probably until after the next menstrual period.

Suction Method - "Vacuum D and C"

This is also a safe, quick (about 10 minutes), and simple abortion procedure for a pregnancy less than three months. Again, the cervix is dilated; but this time, a clear, plastic tube, an aspirator, is inserted into the uterus, and the fetal material is withdrawn by a slow suction. As soon as the tissue passes through the tube, the doctor checks the contents of the uterine cavity to make sure that no material has been left behind. This prevents infection as well as excessive bleeding. Done under anesthesia, it is as simple and as safe as the D&C described above.

METHODS OF TERMINATING A PREGNANCY AFTER THREE MONTHS

Hysterotomy - done between 12 and 24 weeks of pregnancy

This procedure is used when the fetus is too large to be aborted by dilatation and curettage. It is not a hysterectomy - which is the removal of the entire uterus. They are completely different operations.

It is, however, major surgery. The fetus is removed from the uterus in much the same way as a baby is removed at the time of a Caesarean. It involves cutting through the abdominal wall and the uterine wall and removing the fetus from the uterus. Generally, a woman will need about a week's rest in the hospital following the operation. Hysterotomy is usually performed at Yale when a sterilization procedure is also indicated. Since female sterilization involves opening the abdomen, hysterotomy is considered appropriate as a way to combine both procedures at the same time.

Saline Injection - 16 to 24 weeks

A newer and much simpler procedure now promises a safe abortion without major surgery even after 3 months gestation. It seems to be a great improvement over the hysterotomy. Although there are possible complications, the technique is a simple one. The doctor locally anesthetizes a small area of skin below the navel. A needle is used to penetrate the abdominal wall into the cavity of the uterus. This needle withdraws the amniotic fluid which surrounds the fetus, and through the needle the fluid is replaced with a salt solution. In most patients the uterus starts to contract within 24-36 hours and expels the fetus and placenta.

PROPOSED TECHNIQUES OF ABORTION

The methods described above, although commonly used and considered to by very safe, nevertheless have complications associated with them. At the time of a D&C there may be excessive bleeding or the uterus may be perforated. A saline injection does not always work and occasionally a patient who has had a saline injection must have a D&C following it.

All these methods have risks associated with them (as does anesthesia), and newer methods are being sought. Recently described is the use of prostaglandins for abortion. We are most fortunate here at Yale to have been given prostaglandins to be used to induce abortion. It is planned to give the prostaglandins by simple intravenous injection and thus not require anesthesia. This will hopefully avoid complications seen with other methods of abortion. The prostaglandins work by causing uterine contractions which are strong enough to expel the pregnancy tissue. It is probably worth noting that **at** the present time, Yale is one of the only hospitals in the country to be given prostaglandins for use as an abortafacient (an agent which causes abortion). They are at present being used in other parts of the world with great success and it is our feeling and the hope of the Gynecology Department here that the results seen

in Sweden, England and Africa will be replicable in New Haven.

NON-HOSPITAL ABORTIONS

If you are under 21 you will need parental consent to have an abortion at Yale-New Haven or most any hospital. Knowing that this will cause unhappiness, disappointment, or real anger in your parents, you may be tempted to find a private abortionist, not connected with hospital facilities. Don't. We don't like to preach - but truly death or permanent disability is not a worthwhile alternative to facing parents with your problem. Not everyone suffers from a criminal abortion, but it is a terrible risk to take - especially when you don't have to. Those students aborted last year who were under the age of 21 were able to involve at least one of their parents, and this was all that was necessary. In almost all instances, the feeling afterwards of the family as well as that of the couple involved was that involvement of the family turned out to be a very good thing in helping the couple handle the crisis.

Opportunity to receive an abortion in this country discriminates against the poor, the ignorant, and the disadvantaged. The situation is getting better, but at this writing, college students are among a privileged group. You are privileged in that you have access to information that some would and many have given their lives for in previous times when abortion was a suppressed and criminal practice. If it is impossible for you to have an abortion done at YNH Medical Center the Counseling Service at Dept. of University Health will help you to find a non-hospital abortion done by a physician under safe conditions. In New Haven, the most reputable referral service can be found by calling the Clergy Counseling Service for Problem Pregnancy at 624-8646. If you can bring them a doctor's note (which the physician at DUH will be glad to give you) stating that you are definitely pregnant and for how long you have been pregnant, they will arrange help for you. Similar organizations exist in many American and Canadian cities. Concerned clergymen, seeing a

desperate need, have been able to help frantic women find skilled physicians in order to avoid the atrocities of criminal abortion. The recommended physicians will use anesthetics and follow standard procedures. Since the change of the New York state law and the development of office and other out-of-hospital abortions in New York, the clergymen have been able to help women on a large scale. It is our feeling, however, that for the student at Yale, far and away the best service that can be offered is through the Department of University Health.

SAFETY OF A MEDICAL ABORTION

Under current circumstances a medical abortion done in a hospital is a safe procedure. The complications are similar to those of a tonsillectomy, although on rare occasions serious complications are encountered. Still, we do not know what all the medical complications of abortion are. At the present time, a study is being done by the Rockefeller Foundation to determine what the extent of complications such as perforation of the uterus, hemorrhage, infection, and death is in a large series of patients legally aborted. We do know that criminal abortion in this country has been responsible for a significant number of female deaths each year. We also know that in the communist countries where abortion has been done legally on a large scale through clinics, the complication rate is very small. And, in those countries abortion has turned out to be a safer procedure than having a baby.

COSTS

Here is the rub. Even at minimal charges, expenses at any hospital, Yale included, pile up. Costs come to between $400 and $500. (A half hour in an operating room today for any reason costs a patient about $100 just for the room. The other costs are for anesthesia, nursing, hospital bed, laboratory work, and the doctor's fee.). Exceptions and terms may be arranged, but at the present

time, any way you look at it an abortion is a great deal more expensive than buying the pill once a month. An illegal abortion may cost you anywhere from $400 to $1000 - of course, that is not counting the money any complications and check-ups may cost and certainly not including the added fear and anxiety. Efforts are being made to bring costs down to a feasible scale, and this has been accomplished somewhat both here in New Haven and in New York. But, at the present time abortion is still a large expense.

THE FUTURE OF ABORTION IN THE UNITED STATES

While the trend in abortion laws seems to be towards liberalization, abortion is still not a simple decision by a woman who wishes to end her pregnancy. Although Yale-New Haven has a more equitable procedure than most, it still entails seeing a psychiatrist, getting permission from a hospital committee, paying out large sums of money, and going through channels. Furthermore, even if abortion should become a totally individual decision (it is almost at that stage now), it would not eradicate all of the tension, ambivalence, and emotional upset of having to terminate a pregnancy. While the abortion can be made into a positive part of one's education, it is not an essential lesson.

Some Eastern European countries have abortion clinics that perform abortions with much the same gravity that Americans accord to having a mole removed. Women go in on a lunch break or after work and for a nominal fee, are aborted. (It costs $1.12 to have an abortion in Prague - and $1.75 a month to take the pill).

It is this committee's opinion, however, that while more enlightened abortion procedures are essential, we would not like to see abortion as a means of birth control. Abortions - even inexpensive, quick abortions - demand decisions, emotions, and professional time that need not be so utilized if an effective birth control program is being used. Hopefully, birth control methods will soon be so widespread and so sophisticated that the need for abortions will decrease. In the meantime,

should a birth control failure occur, abortion will be increasingly available.

venereal disease

A recent article in the New York Times reported that venereal disease is the second most common communicable infection in the United States; only the lowly cold occurs more frequently among the American populace. Over one and a half million cases of the two major veneral diseases, syphilis and gonorrhea, are recorded each year, and several times that number are treated by physicians, but not registered with public health authorities. Venereal disease has also been spreading particularly fast among the young; the Times noted that every two minutes a teenager gets VD somewhere in the United States.

Cases of syphilis and gonorrhea have in recent years been quite rare at Yale, a fact that may be explained by the general decrease of college students' experience with prostitutes. However, VD respects no class of people; it is imperative that anyone who even vaguely suspects he has VD seek medical treatment immediately. Caught in the early stages, both syphilis and gonorrhea can be cured fairly easily by penicillin and other drugs. But, in the absence of such treatment, syphilis can lead to severe disability and death, and gonorrhea can lead to permanent sterility.

Venereal diseases are almost always contracted through intercourse or other intimate sexual contact (both hetero-and homosexual). Only extremely rarely are they transmitted through objects such as towels or toilet seats. On the other hand, syphilis and gonorrhea are highly infectious; the condom is the only birth control method to help protect against them, but even it is far from 100% effective.

The first symptom of syphilis is a sore that appears, usually in the genital area, from ten days to three months after exposure to the disease. The most characteristic time for the sore to appear is about three weeks after contact with an infected person. Often the sore is small, and it may not even hurt. On

occasion, a woman can be unaware of its existence. Left untreated, it will go away by itself in several weeks, but the disease is still present. Later, a secondary symptom, most notably a rash on part or all of the body, may appear, but it too disappears without treatment. Then the disease enters a latent stage, giving no visible clues to its presence. But five to fifty years later, the syphilis germs can attack the heart or nervous system. Paralysis or death may result. The disease can also be passed on congenitally to newborn children; unless a syphilitic woman is treated early in pregnancy, she will bear a stillborn or blind child. For this reason, state laws usually require a blood test for syphilis before a marriage license is issued. If the test is positive, the condition can be treated before pregnancy. Unfortunately, since so many brides are already pregnant, the blood test is far from an effective means of eliminating syphilis in the newborn.

As for gonorrhea's symptoms, approximately three to nine days after exposure to the disease, a male experiences severe burning upon urination. Then a thick yellow discharge becomes apparent. Such a discharge also can occur in an infected female; however, 80% of women with gonorrhea have no early noticeable symptoms. For both men and women the disease, if not treated, can result in severe comlications including bladder inflammation, arthritis or irritation of the joints, eye infections, and sterility.

Syphilis and gonorrhea are diagnosed primarily by a blood test and a bacterial culture, respectively. By law in twenty-four states (including Connecticut) a doctor is authorized to test and treat minors for VD without the consent of parents. All cases of VD are supposed to be reported by doctors to the Department of Health, but this requirement is chiefly designed to help in the identification of the sexual contacts of the infected person so that they can be located and treated before they spread the disease even further. So if a Yale student suspects he has VD, he should go to the DUH to be examined. His case will be treated with full confidentiality.

Before ending this section, brief mention must

be made of a family of common fungus infections whose symptoms are sometimes mistaken for those of VD. These infections, though annoying, are not serious.

Many women on birth control pills and many women who douche experience a change in the organisms which live in the vagina resulting in an overgrowth of a yeast called monilia. The symptoms are itching, and/or excessive discharge, and/or burning with urination and not infrequently dryness of the vagina or discomfort during intercourse. This kind of infection is easily treatable and does not forbode all the complications of venereal disease. In males, the yeast may manifest a burning with urination or discomfort at the tip of the penis. Monilia is treated with a locally applied medication for a period of 10 days. Another organism, trichomonas, causes similar symptoms. Treatment involves both partners and consists of taking oral medication for a period of ten days. The two conditions are usually distinguished by the physician with microscopic and/or media-culture examination of the vaginal or the penile secretions. Although the student may confuse these conditions with the venereal diseases, monilia and trichomonas do not cause the complications of syphilis and gonorrhea. Both monilia and trichomonas are very common and easily treated.

When one realizes the high incidence of VD in the age group of our population that is in college, it may be baffling to find such a low rate on the Yale campus. We think the reason is that VD is a symptom of promiscuity and that promiscuity is not common on this campus. After all, you get VD from someone who got it from someone else.

yale services

The purpose of this last section is to acquaint you with the services available to you as a Yale student. The services are broad enough so that you should be able to find someplace to go that is comfortable for you no

matter what your problem or question may be. There are plenty of capable and trained people who want to listen to you and who can help you if you need it - always confidentially.

DEPARTMENT OF UNIVERSITY HEALTH

The Department of University Health, hereafter referred to as DUH, offers the usual medical and surgical services as well as special services in the areas of sex counseling, contraception, abortion, and mental health. Among modern universities, Yale is almost unique in its creation of a special department at DUH to deal with the sexual problems and questions of its students. The service is a part of the mental hygiene clinic which in itself is regarded both by students and on a national level as an outstanding program. So consider yourself very lucky.

Sex counseling is done by Dr. and Mrs. Sarrel, a gynecologist and a social worker. The Sarrels work together as a team. The counseling services are offered at DUH by appointment on Mondays and Wednesdays only. To make an appointment call 436-3736.

The psychiatric staff sees patients daily by appointment (436-3736). In addition, a psychiatrist is designated each day for emergencies and is on 24 hour call to students. During Clinic Hours (8:30 a.m. to 5 p.m. weekdays and 9:00 to 12:00 on Saturdays during term time) the on-call psychiatrist can be reached through the Mental Hygiene Division reception desk (436-3736) or by coming to the desk on the third floor of DUH. At night and on weekends the on-call psychiatrist can be reached through the Yale Infirmary (436-0454). Students with sexual questions and problems can freely turn to the services of the Mental Hygiene Clinic as well as the sex counseling program.

The Mental Hygiene Division provides consultation and psychotherapy, both individual and group, for a variety of emotional problems, some of which may be related to sexual concerns. After an initial evaluation interview, if it is decided psychotherapy is appropriate,

the student will be assigned to a therapist and seen on a weekly basis, usually for a 50-minute session. The number of weekly sessions may be (but is not always) limited to 15. In many instances, however, the immediate problem may be resolved in fewer visits. Sexual problems that students have come with cover a wide range and may include such diverse concerns as difficulties in heterosexual relations, impotence, fears of homosexuality, guilt over masturbation, dissatisfaction with homosexual orientation, frigidity, worry about unusual sexual interests, and general feelings of sexual inadequacy.

Some problems because of their severity and duration may require more intensive treatment than is offered in the Mental Hygiene Division. In these instances, however, it may be helpful to discuss the situation and consider possible alternatives. If referral is appropriate the Division will help as much as it can in effecting such referral.

Also at DUH is another gynecologist who is available to those students who have problems such as painful or irregular periods, vaginal discharge or itching, infection, and other purely gynecological matters. Routine birth control (where there is no question about which kind of method is desired or when getting a refill on a prescription for the pill) will be taken care of, too, by the DUH gynecologist. He is available on Tuesday and Thursday. Appointments are made by calling 436-4730.

ABORTION UNIT

A special unit has been created at the Yale-New Haven Hospital. Access to this unit is available to all students through DUH. In accordance with Connecticut law, all women desiring a legal abortion must be seen by a gynecologist and a psychiatrist. Students who need and wish these services will be referred by DUH to the hospital unit responsible for submitting a petition to the hospital committee. If the petition meets the requirements of Connecticut law, it will be granted. The decision is reached in a few

days'time. All students for whom permission was requested last year were approved.

Parental consent is required by law for minors for any operation, however slight. Abortions are in no way different, so if you are under 21 and desire a legal abortion, at least one of your parents must give consent. In many cases, it is appropriate for one's boyfriend to be involved in the discussions with the professional staff. The cost for abortion is about $400.00. This cost includes all follow-up visits.

If it is impossible for a student to tell her parents, and she is under 21, she will be referred through DUH to the Clergy Counseling Service for Problem Pregnancy where she will be told how and where abortion can be performed safely and legally.

In providing abortion, the university hospital can only serve women who reside in the New Haven County. Students living on and off campus are considered residents of New Haven. However, counseling will be provided for all student couples. For men whose girlfriends live in other communities, there is a direct communication network with schools throughout the country, and these girls will be counseled as to where they can get a legal abortion in their own community.

REMEMBER, THERE IS ALWAYS SOMETHING YOU CAN DO. DON'T TAKE A CHANCE WITH AN ILLEGAL ABORTIONIST. IT COULD MEAN YOUR LIFE.

THE CHAPLAINS

The Chaplains at Yale do various kinds of counseling. Some of the men are trained in dealing with problem pregnancies or abortion referral, some in giving supportive therapy and vocational guidance, and some in exploring together with students areas of interpersonal relationships, as in marriage counseling or in problems with homosexuality. Through the Chaplain's Office at 258 Durfee Hall, students can be referred to any of the Chaplains. The phone number there is 436-4691 or 436-4692. It is always good to

make an appointment, though not always necessary.

The Chaplains are available almost all of the time to explore problem issues with a student and to offer counseling. Because counseling is often rooted in strong, warm, and frank discussion, it becomes for many students a deeply supportive and healing series of meetings. However, such experiences cannot be summarized in a few words.

One of our chaplains, Phil Zaeder, became very interested in the Course in Human Sexuality, and he helped to plan it when it was first given in the spring of 1970. A good deal of his time is spent with students who are contemplating marriage and who need a mirror to help them sort out some of their feelings and values, including their sexual self-understanding. Also, on the basis of experience with various courses in human sexuality and training in psycho-drama, he has worked with several students with homosexual difficulties.

Again, through the office at 258 Durfee, you can be referred to any of the Chaplains at Yale. They are all available to help you as you need it.

THE COURSE IN HUMAN SEXUALITY

The course in human sexuality that is given at Yale is designed like most of the other Yale student services, with the Yale student in mind. The course was given here for the first time last spring with 1000 students attending. Similar courses had been, and continue to be, offered at Brown, Mt. Holyoke, Smith, and Amherst. The course, a non-credit one, will again be offered during the 1970-1971 academic year. As in the past, changes will be made that will probably reflect the suggestions students made in their evaluation of the previous year's course. Lectures to be given will include discussion of interpersonal relationships, and their effect upon sexual

behavior, sexual problems on the campus, orgasm and sexual response, birth control, pregnancy and birth, and abortion. In addition to the lectures, however, the most essential and perhaps the most rewarding aspect of the course is the seminars. These are co-ed groups of about 15 students guided in discussion by a student group leader. The groups meet weekly after the lectures. This is a good place to express your feelings, listen to others, learn about others, and to learn about yourself.

The first course had too few women attending compared to the number of men, thus making a course in human sexuality less meaningful than it could have been. This was perhaps its greatest weakness. Therefore, in the future, registration will be limited to 500 students, 250 men and 250 women. Enrollment in the course is open to all Yale students. However, a separate course is offered at Yale Medical School for medical students, a course is being developed at the Law School, and the Divinity School has offered a course in human sexuality.

Registration information and the exact time and place of the course are provided in a separate leaflet in this pamphlet. The course costs $5.00 to cover the costs of books and other course materials. The money that was left over from this year's course was used to make this pamphlet possible at no cost to students. For further information please call Elaine Fox at 432-1631.

WOMEN'S LIBERATION

Women's Liberation aims at changing the cultural, psychological, and political patterns that continue to oppress women. In our community, there are five Women's Liberation groups, differing from each other mostly in the memberships upon which they draw. However, they are all open to all women.

New Haven Women's Liberation, whose members are drawn from the city of New Haven, is closely related to its four sister groups in the Yale community. The meetings of New Haven

Women's Liberation are every Sunday evening at 7:30 in the AIM (American Independent Movement) Office which is at 148 Orange Street, over the Buster Brown shoe store. For further information call the AIM Office at 787-0123. New Haven Women's Liberation is your best source of information about the other Women's Liberation groups in the community.

The Yale Break periodical is published by New Haven Women's Liberation. Consciousness raising groups are also held weekly. More importantly, however, New Haven Women's Liberation sponsors a course called "Women and Their Bodies" which was first given in the summer of 1970. This course will probably be given again in the fall, so watch for notices or call the AIM Office if you are interested.

The Yale Women's Alliance members are, for the most part, graduate women. They will probably be meeting on Tuesday nights at 7:30 in 218 HGS. Contact Shelley Taylor at 776-1750 for further information. Especially noteworthy was the Yale Women's Weekend that the Women's Alliance sponsored in February 1970. The weekend included a day of workshops in such areas as Sexuality, Women and the Law, Motherhood, Working Mothers, and Day Care, and a day of speeches to which men were admitted. The Women's Weekend succeeded in raising the consciousnesses of many, and it proved enlightening for both women and men.

The Sisterhood is that Women's Liberation group whose membership consists mostly of undergraduate women. The Sisterhood was quite active during the May 1 weekend, establishing at that time a center for women.

The Law Women's Group has a membership that includes both women law students and male law students' wives. This group started a credit course on "Women and the Law" that is given at the Law School.

The Medical School also has a Women's Liberation Group whose members are mostly women associated with the medical complex.

Again, these groups differ mainly in membership; their functions and goals are nearly the same. The groups will all meet regularly in the fall.

The best way for you to get information about any of the groups is to call New Haven Women's Liberation at 787-0123.

Women's Liberation in our community is also divided into groups on an issue-oriented basis, rather than on a membership basis only. Projects such as an Abortion Law Suit, Child Care at Yale, and the course on "Women and Their Bodies" involve groups of women from all of the membership groups.

In addition to Women's Liberation sponsored courses, Yale College offers some courses on women. Psychology 92, a new course to be offer d, is called "Psychological Perspectives on the Study of Women". It will be a seminar. There will probably be a course on "Women in Sociology" also. However, these are just some examples. There will be several courses on women offerred in the various departments and as college seminars. The Yale Course of Study catalogue is your best resource if you are interested in such courses.

HOMOSEXUALITY DISCUSSION GROUP

The Homosexuality Discussion Group was formed to serve both a social and an educational function for interested members of the Yale Community. Its program is designed for two types of persons: first, for the man or woman who has accepted or is discovering within himself tendencies toward homosexuality; and, second, for those heterosexuals who are genuinely interested in the homosexual as a person and in the homosexual group as a very real facet of modern society.

The Homosexuality Discussion Group met regularly during the past academic year. Some of the topics of discussion were "The Homosexual at Yale," "The Homosexual in the European University", "The Homosexual and Social Change", and "Legal Problems of the Homosexual". Informal discussions over coffee have also been held regularly, and not wanting to neglect the necessary social functions of the organization, the group also sponsored several parties in the Dwight Hall Common Room.

Meetings have been regularly attended by more than 40 people, which is an indication that there is a need for and an interest in this kind of a group at Yale. Many students have been relieved to find that they are not alone as homosexuals; there are others on campus having the same interests and difficulties. The Homosexuality Discussion Group is a place where anyone can come to talk, to listen, to be himself.

Meetings are regularly held at 9:00 p.m. on Thursday evenings in Dwight Hall and are announced in the Yale Daily News, the Yale Graduate Professional, and the University Calendar. Anyone who has a question or who would like to contact a member to talk to can write a note to Box 2031 Yale Station, New Haven, 06520. Naturally, all communications are treated confidentially.

ZPG

Zero Population Growth, Inc., commonly known as ZPG, is a non-profit volunteer group concerned with the population crisis. Its goal is a stabilized population size in the U.S. ZPG is a national organization that was started in Connecticut, and now has its headquarters in California. It encourages active participation of individuals through local and campus chapters. In fact, in October 1969 a Yale chapter of ZPG was formed in addition to the already existing New Haven chapter, and the Yale group has grown very fast.

ZPG earns mention in this pamphlet because the crisis of overpopulaion is one that seriously affects everyone now, even you, and will even more so in the future. ZPG, being political and educational in nature: presses for education and publicity on the overpopulation problem; encourages politicians, administrators, and leaders of opinion to take a positive stand on the need for population stability; encourages and publicizes development and use of simple and effective contraceptive devices; campaigns for the repeal of laws restricting voluntary abortion and sterilization; encourages couples to have only

2 children of their own, and to adopt children if they feel that they want more; encourages changes that raise the social status of unmarried people and childless couples, and that lead couples to see that more than 2 children in a family are undesirable both for society and for the children's future; and encourages education and understanding concerning the relationship between man and his environment and our responsibilities to future generations. ZPG also employs a lobbyist in Washington, D.C. to work to achieve their political aims. And, on the local level, ZPG has sponsored such things as an exhibit in the Peabody Museum, light shows (in Yale's residential colleges) about man and his environment, and joint programs with the New Haven chapter.

By joining ZPG, you will be taking action to protect the environment that you, your children, and your grandchildren will have to live in. All members receive a monthly newsletter from the national organization, and also chapter newsletters. ZPG has a special student subscription rate of $2.00 per year, half of which is kept by the local chapter, the other half being sent to the national office. For information about the Yale Chapter of ZPG drop a note to 1947 Yale Station, or watch for ZPG sponsored programs on campus.

conclusion

Perhaps you are now brimming over with questions that you hadn't thought of before reading this pamphlet. Or, maybe we were able to answer a few of your questions and to give you a little bit of information that you wanted. In any case, we hope that we have provided you with some practical ways in which you can cope with your problems (and pleasures) if and when they arise.

The Committee on Human Sexuality

suggested bibliography

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